Assembly Bill No. 1496

CHAPTER 579

An act to amend Section 1374.34 of the Health and Safety Code, relating to health care.

[Approved by Governor September 28, 2003. Filed with Secretary of State September 29, 2003.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1496, Montanez. Health care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan to establish an independent review process to examine coverage decisions, and requires the Director of the Department of Managed Health Care to require a plan to reimburse an enrollee for reasonable costs of urgent care or emergency services obtained outside of the plan provider network if the enrollee's decision related thereto was made prior to completing the plan grievance process or seeking an independent medical review but was reasonable, a subsequent independent medical review determines the services that were medically necessary, and the services were a covered benefit under the plan contract.

This bill would revise the reimbursement requirement so that the director must require reimbursement if the urgent care or emergency services are determined to be medically necessary, the services were a covered benefit, and either the enrollee's decision to secure the services was reasonable or the plan does not require or provide prior authorization for the services.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.34 of the Health and Safety Code is amended to read:

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written

decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not implemented. Administrative penalties shall be deposited in the State Managed Care Fund.

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent medical review organization to have been medically necessary pursuant to Section 1374.33, and either the enrollee's decision to secure the services outside of the plan provider network was reasonable under the emergency or urgent medical circumstances, or the health care service plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan

to provide those health care services to enrollees or subscribers is reasonably clear.

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